MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
DIVISION OF REGULATION AND LICENSURE
SECTION FOR LONG TERM CARE REGULATION

RESIDENT CARE SURVEY – ICF/SNF

INSTRUCTIONS: A facility representative will complete items 1-25 on page 1, and items 26-29 on page 2 of this form. Information should be as complete and accurate as possible.

FACILITY NAME	FACILITY ID NUMBER	DATE

ADDRESS (STREET, CITY, STATE, ZIP CODE)

TOTAL CAPACITY	CURRENT CENSUS

NUMBER OF RESIDENTS	CATEGORY
	1. Residents with severely impaired vision or blind
	2. Residents with highly impaired hearing or deaf
	3. Residents who are bedfast 22 or more hours each day
	4. Residents who are bed-to-chair only and require total assistance
	5. Residents with indwelling catheters
	6. Residents incontinent of bowel/bladder (do not count residents with indwelling catheters)
	7. Residents on planned and written bowel/bladder program
	8. Residents who are confused and disoriented at all times
	9. Residents requiring total assistance with meals and fluids
	10. Residents on mechanically altered diets
	11. Residents on therapeutic diets
	12. Residents on tube feedings (NG or gastrostomy)
	13. Residents with colostomies, ileostomies, or tracheostomies
	14. Residents receiving special skin care
	15. Residents who are suctioned at least daily or more
	16. Residents receiving inhalation therapy or oxygen at least daily or more
	17. Residents receiving physical, occupational and/or speech therapy
	18. Residents physically restrained
	19. Residents with unplanned weight loss or gain
	20. Residents on dialysis
	21. Residents on hospice or terminal care
	22. Residents on pain management program
	23. Residents with psychiatric diagnosis
	24. Residents with mental retardation

PLEASE CONTINUE ON PAGE 2

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RESIDENT CARE SURVEY – ICF/SNF (Continuation Sheet)

CATEGORY AND SPECIFIC INFORMATION

Please give a detailed breakdown of all residents with the following as indicated below.

26. Residents with pressure ulcers on admission (list below)

ROOM #	NAME	SITE OF PRESSURE ULCERS	I	II	III	IV	UNSTAGEABLE	DATE ADMITTED
			☐	☐	☐	☐	☐	
			☐	☐	☐	☐	☐	
			☐	☐	☐	☐	☐	
			☐	☐	☐	☐	☐	
			☐	☐	☐	☐	☐	
			☐	☐	☐	☐	☐	
			☐	☐	☐	☐	☐	

27. Residents with pressure ulcers developed or acquired in this facility (list below)

ROOM #	NAME	SITE OF PRESSURE ULCERS	I	II	III	IV	UNSTAGEABLE	DATE OF BREAKDOWN
			☐	☐	☐	☐	☐	
			☐	☐	☐	☐	☐	
			☐	☐	☐	☐	☐	
			☐	☐	☐	☐	☐	
			☐	☐	☐	☐	☐	
			☐	☐	☐	☐	☐	
			☐	☐	☐	☐	☐	
			☐	☐	☐	☐	☐	
			☐	☐	☐	☐	☐	

28. Residents currently on antibiotics (list below)

ROOM #	NAME	ANTIBIOTIC	SITE OF INFECTION	DATE STARTED

29. Residents transferred to hospital or discharged from facility during last thirty (30) days (list below)

ROOM #	NAME	REASON FOR TRANSFER	LOCATION	DID THEY RETURN?

I AFFIRM THE ABOVE INFORMATION TO BE AN ACCURATE STATEMENT TO THE BEST OF MY KNOWLEDGE.

SIGNATURE OF FACILITY EMPLOYEE PROVIDING INFORMATION (ITEMS 1-29)	PLEASE PRINT NAME AND TITLE OF PERSON SIGNING FORM	DATE